OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY

Comprehensive Quality Review Report

Cheltenham Youth Facility

May 16, 2008

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY
Quality Review Report

Cheltenham Youth Facility

Evaluation Dates: April 22-28, 2008

TABLE OF CONTENTS

TABLE OF CONTENTS
continued

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY
Quality Review Report

Cheltenham Youth Facility
Facility Superintendent: Reginald Garnett
Evaluation Dates: April 22-28, 2008

EXECUTIVE SUMMARY

A quality improvement assessment and evaluation of the Cheltenham Youth Facility was conducted April 22-28, 2008 by DJS personnel who are subject-matter experts in the areas reviewed. The areas that were evaluated have been identified as those having the most impact on the overall safety and security of youth and staff. The evaluation was based on information gathered from multiple data sources such as staff interviews, youth interviews, document review and observations of facility operations, activities and conditions.

The following Rating Scale was used:

Quality Improvement Rating Scale

Superior Performance	Strong evidence that all areas of practice consistently exceed the standard across the facility/programs; innovative facility-wide approach is incorporated sufficiently so that it has become routine, accepted practice.
Performance	Performance measure is consistently met across the facility/program; any gaps are temporary and/or isolated and minor; documentation is organized and readily available.
Partial Performance	Expected level of performance is observed but not facility-wide or on a consistent basis; implementation is approaching routine levels but frequently gaps remain; facility had difficulty producing documentation in some areas.
Non-performance	Little or no evidence of adequate implementation of performance measure; the required activity or standard is not performed at all or there are frequent and significant exceptions to adequate practice; documentation could not be produced to substantiate practice.

A total of **40 standards** were evaluated with the following results:*

Rating	# within rating	% of total in rating
Superior Performance	4	10%
Performance	21	52.5%
Partial Performance	14	35%
Non-Performance	1	2.5%

*** The DJS Quality Improvement Performance Ratings are aligned with best practices and optimal standards of care. Therefore, while the facility practice may be in full compliance with minimum constitutional standards, the facility may still receive partial or non performance ratings as a result of QI reviews.**

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY

Cheltenham Youth Facility

Executive Summary of Results

Superior Performance	Performance	Partial Performance	Non Performance
Fire Safety	Incident Reporting	Senior Management Review	Control of Keys, Tools & Environmental Weapons
Informed Consent	Perimeter Checks	De-escalation & Restraints	
Environmental Hazards	Contraband & Room Searches	Seclusion	
Student Supervision	Admissions, Intake & Handbook	Room Checks During Sleep Period	
	Pending Placement	Youth Movement & Counts	
	Intake, Screening & Assessment	Post Orders	
	Psychotropic Medication Management	Staff Training	
	Behavioral Health Services	Staffing	
	Treatment Planning	Classification	
	Behavioral Health Treatment Delivery	Behavior Management	
	Clinical Care for Suicidal Youth	Structured Rehabilitative Programming	
	School Entry	Self Assessment	
	Curriculum and Instruction	Transition Planning	
	School Staffing & Professional Development	Documentation of Youth on Suicide Watch	

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY

Cheltenham Youth Facility

Executive Summary of Results

Superior Performance	Performance	Partial Performance	Non Performance
	Screening & Identification		
	Parent, Guardian & Surrogate Involvement		
	Individualized Education Programs		
	Career Technology & Exploration Programs		
	Section 504 Plans		
	School Environment/ Climate		
	Health Care Inquiry Regarding Injury		

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY

Cheltenham Youth Facility

METHODOLOGY

I. Pre-Evaluation

Prior to the evaluation, the facility received a document request list from the DJS Office of Quality Improvement. This list detailed various documents in the areas of safety and security, medical care, mental health care and education that would be reviewed by the QI Team. Numerous on-site meetings have been held since the previous QI review in December 2007 including targeted QI reviews.

II. Entrance Interview with Superintendent

No entrance interview was conducted with the Superintendent, due to CRIPA monitors being at the facility at the time. An overview of the QI process was provided to the Superintendent prior to the review and multiple interviews were conducted with the Superintendent throughout the week of the review. Members of the QI Team asked and discussed with the Superintendent targeted questions related to safety and security, behavioral health, behavior management, education, medical and many other areas of facility operation.

III. Primary Interviews

A total of 15 youth were interviewed (no refusals) about a range of areas across the QI review spectrum. This represented about 14% of the total population at Cheltenham that week. The youth were chosen specifically across all units. Interviews were also conducted with facility direct care, administration, medical, behavioral health, and education staff. In addition, 11 staff were interviewed specifically about the target areas of the review as well as their general feelings about the operation of the facility.

IV. Document Review

Documents were reviewed that were requested by the QI Team and provided by the facility staff in support of facility operations and program services. The documents included medical records, incident reports, logbooks, program schedules, seclusion and suicide watch documentation, staffing reports, training records and statistical data, as well as other documents from areas in fire safety and youth supervision.

V. Observations of Facility Operations

- Youth movement
- Youth processing
- Structured programming
- Unit activities
- Recreation
- Leisure Time
- Classroom Activities
- Shift Change

VI. Exit Conference

An exit conference was conducted at the facility on Monday April 28th. Members of QI Team and the Administrative/Management staff of the facility were present. The QI team gave a brief but detailed overview of its findings. The facility administration had the opportunity to ask questions and to clarify or provide additional information. The Superintendent was given information about expectations for the Quality Improvement Plan (QIP), including due dates, and was informed he could expect the written Draft QI Comprehensive Report by May 16, 2008.

SUMMARY OF FINDINGS & RECOMMENDATIONS

SAFETY AND SECURITY

INCIDENT REPORTING **RATING: Performance**

STANDARD

Written policy, procedure and practice document that all incidents that involve youth under the supervision of DJS employees, programs, or facilities, including those owned, operated or contracted with DJS, are reported in accordance with departmental guidelines.

SOURCES OF INFORMATION

- Facility Incident Reports from Feb-Apr 2008
- Interview with Superintendent
- Youth grievances Feb-Apr 2008
- Staff Training records
- Interviews with youth
- Interviews with staff

REFERENCES

DJS Incident Reporting Policy (MGMT-03-07); DJS Crisis Prevention Management (CPM) Techniques Policy (RF-02-07); DJS Video Taping of Incidents Policy (RF-05-07); DJS Youth Grievance Policy (MGMT-01-07)

SUMMARY OF FINDINGS

Comprehensive and reliable reporting of incidents, including detailed descriptions of events, is crucial to a facility's success in preventing and managing critical situations. Only when youth feel they can report allegations and incidents confidentially and without reprisal, and staff members know how to document sufficient information in incident reports, can DJS feel confident in the implementation of its policies and the safety of our youth. The Department has a stringent reporting standard that requires completion of the DJS Incident Reporting Form to identify and describe all reportable and critical incidents.

In addition, DJS employees are required to notify law enforcement and the local Department of Social Services/Child Protective Services (DSS/CPS) of incidents as required by law. In two alleged abuse incidents, both were reported properly to CPS but in one, the nurse left the reporting section on the body sheet blank (it was reported timely and noted as such in the IR) and in the other, the alleged abuse was reported, but not until 6 hours later. Alleged abuse must be reported to CPS immediately upon report by the youth.

The Department requires the facility to maintain an incident report (IR) file with detailed information about every incident. The IR file is to include a copy of the DJS Incident Reporting Form (handwritten and electronic) and supporting documentation (i.e. videotape, witness statements, Nursing Report of Youth Injuries with photograph(s), and other documentation as applicable). All IRs at Cheltenham were locatable and in organized files.

Thirteen incident reports were chosen randomly for review specifically because they involved assaults, restraints, or abuse allegations. Of those 13 IRs, 7 were good or excellent in providing a detailed account of what happened during the incident. Four were not as high quality, but gave an acceptable level of detail and only 2 were not acceptable. Of those poorly written IRs, both were written by medical or clinical staff who are unaccustomed to writing them and have not had the report writing training at the frequency of the direct care staff at Cheltenham.

All of the staff were also able to describe their responsibility to complete an incident report if they are involved in an incident and to ensure that the involved youth is immediately taken to Medical for an assessment. All IRs reviewed included completed body sheets and photographs (more information on their quality is provided in the Health Care Inquiries Regarding Injury section of this QI report.)

Also positive is that all staff interviewed indicated that they do receive feedback after submitting an incident report and/or that IRs are reviewed with them by senior management. It follows that the more feedback staff get, the less likely they are in the future to make the same mistake.

Of the IRs reviewed, there were a total of 39 staff witness statements required to be included and just 7 were missing. Though the Shift Commander should not accept an IR until all staff witness statements are turned in with it, the vast majority of staff did include a witness statement. However, youth witness statements were not always present. All youth witness statements were not obtained in any of the IRs reviewed, though the youth directly involved in the incident typically always provided a written witness statement. It is important to secure a statement from all who observed the event, even if youth write that they saw nothing at all.

On a positive note, when they do secure a statement, Cheltenham tends to get most youth to write what actually happened rather than writing “no comment” as many youth tend to do. It might be worthwhile to review Cheltenham’s staffs’ methods for ensuring that all youth witnesses provide their observations to disseminate these successful approaches to improve the percentage of completed witness statements at other facilities.

The DJS incident reporting standard also requires that youth have the opportunity through a grievance process to report issues confidentially and without fear of reprisal. A total of 10 grievances were submitted during the monitoring period. Of those, all were retrieved and promptly resolved .The one significant grievance concerned a youth receiving the wrong medication and this was handled promptly and appropriately. The incident

occurred on 2/23; the grievance was submitted on 2/24 and retrieved by the Youth Advocate on 2/25. The youth met with the Advocate, saw the doctor, and agreed that the issue had been resolved on 2/25 (the nurse responsible was also disciplined).

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Enroll clinical staff in report writing training so that they are aware of expectations for critical incident reporting.
- Ensure Shift Commanders review all IRs prior to accepting them to ensure they are complete and thorough, including all witness statements**.**

SENIOR MANAGEMENT REVIEW — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that incident reports are reviewed and critiqued by shift commanders and critical documentation, such as incident reports, suicide watch and seclusion paperwork, are routinely audited by senior managers within DJS timelines and corrections are made by staff timely.

SOURCES OF INFORMATION

- Review of Incident Reports
- Interviews with staff
- Interview with the Superintendent

REFERENCES

DJS Policy MGMT-03-07 Incident Reporting Policy (MGMT-3-01); ACA 3-JDF-3B-10 and 3-JTS-3B-11

SUMMARY OF FINDINGS

The Senior Management Review (SMR) is a necessary component of the effective and efficient operation of detention facilities. Shift Commanders, Group Life Managers and Facility Administrative personnel offer a broad range of experience and insight into why incidents occur and how they can be prevented as well as about youth treatment and care and troubleshooting problem situations.

DJS Policy requires that an administrative review of an incident be completed within 48 hours. The SMR process is essentially a two part review: the first part consists of the initial Shift Commander's review/comments which constitutes a critique that is included in the incident report. The second part of the process takes place after the incident report is completed, and is done by staff at the Group Life Manager level or higher. This is the IR Audit. A final piece of oversight is the OIA (Office of Investigations and Advocacy) investigation process.

Initial Shift Commander Review:

The quality of the comments and critique in the IRs at Cheltenham has definitely improved. Of the 13 IRs reviewed, 8 (62%) contained either an excellent or good shift commander review. Of the remaining reviews, 4 were fair and only 1 was poor in its content and quality (it was merely a re-hash of the events already relayed by the direct care staff.) Though not perfect, progress was evident. The Superintendent has made it a priority to coach shift commanders personally when they are writing these comments and that one-on-one time and persistence is paying off in overall quality. Eventually, the QI Team would like to see the Superintendent be able to ease away from this responsibility as his shift commanders become more experienced implementing this expectation.

IR Audit:

All of the IRs reviewed had been audited by a senior manager (usually the Assistant Superintendent) but 3 of the 13 were not completed. The various blank areas meant the IR had not been thoroughly scrutinized. Of the other 10 audits, most had corrections that were required to be made and turned back in, but 3 of those were not returned by the due date. Still 7 others had no due date given at all so it is unclear what the expectation was for time of return. Consistently identifying due dates and tracking responses would assist the facility to meet this expectation.

For the 13 IRs and the associated audits reviewed, the length of time between incident and audit averaged 4.6 days. This is longer than the 2 days required by policy, but within a reasonable period of time.

OIA Investigations: The Office of Investigations and Advocacy completed three investigations during the QI review period. All of the investigations responded to the corresponding IRs and all seemed to come to reasonable conclusions. The only concern of the QI Team was that each witness' section was listed with that person's name and "date of interview" but the information in some of those sections was nearly word-for-word from a written witness statement. Though it is true some youth may be unavailable for a personal interview (or unwilling to be interviewed) and that written statements are referenced, it should be made clear that the information was not from a personal interview on a particular date, but was instead from a written statement. There might also be included some explanation as to why a youth was not personally interviewed (refused, sent to out-of-state placement, etc.) This clarification would reinforce the integrity of the investigative process.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Complete audits for all IRs daily and work towards doing so within 48 hours.
- Consider requiring all corrections to be returned within a fixed amount of time (two days or four days are good places to start) following audits so that due dates are standardized and timely response becomes the norm.
- Fine tune the system for tracking the incident reports that require corrections following audits, and ensure the due dates are adhered to through use of a tickler system.
- Utilize the shift commanders who are more skilled in the Shift Commander Review portion of the IRs to train their colleagues through .coaching to improve their critique skills..
- Ensure OIA Investigators clarify whether the information they report was obtained through a personal interview or retrieved from a witness statement.

DE-ESCALATION and RESTRAINT — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document the use of verbal crisis intervention techniques to de-escalate a situation prior to the use of physical restraints. Physical restraints are used only when necessary and the least restrictive physical restraint is used first. Incidents involving physical restraints are video taped.

SOURCES OF INFORMATION

- DJS Incident Reports from Feb-Apr 2008
- Facility training spreadsheet
- Interview with Superintendent
- Interviews with youth
- Interviews with staff

REFERENCES

DJS Incident Reporting Policy (MGMT-03-07); DJS Crisis Prevention Management (CPM), Techniques Policy (RF-02-07); DJS Video Taping of Incidents Policy (RF-05-07); ACA 1-SJD-3A-14-15

SUMMARY OF FINDINGS

DJS policy requires a continuum of interventions to be followed prior the use of physical restraint including verbal requests, non-verbal strategies, directive touch and related techniques. Physical restraint should be used as a last resort or if the youth poses an immediate and imminent threat to self or others or if the event of an attempted escape. In order to assess proper CPM technique, the QI Team reviews incident report narratives, videotapes and CPM training records, as well as information from staff interviews and statements from youth.

Youth overall indicated in interviews that staff break up fights when they occur. Staff indicated that they know and use CPM techniques they have learned and nearly all verbalized that de-escalation and the protection of all youth is their main priority when fights occur.

Videotaping of incidents is a good way to review staff's use of physical restraint techniques. The Department's policy encourages the video recording of incidents as this is: 1) instrumental in evaluating the techniques(s) used during a physical restraint, especially without detailed narratives in the incident reports, 2) crucial in absolving staff of unfounded accusations of abuse (e.g. excessive force), and 3) useful as a training tool. Videotapes at Cheltenham are rarely available for incidents and always for the same general reasons (battery dead, battery on charger, other staff had camera, etc.) Additional effort should be made to ensure that cameras are consistently available and operational on all units.

The QI Team reviewed one videotape showing that staff waiting to intervene, even when two youth began bickering and pushing each other. When the youth began fighting, staff seemed to delay responding. When staff did intervene to separate the youth, this was done in a safe manner, but DJS policy requires immediate intervention.

Incident reports (IRs) overall included more detail about the use of restraint than was evident during the QI visit in December 2007. An IR completed in April explained very effectively why staff did not have to restrain the youth to break up a fight. More experienced staff often seem able to de-escalate problems without the use of physical restraints, and the strategies that they use could be disseminated to help train less experienced staff.

DJS policy states that only an employee who has completed DJS approved initial training on the appropriate use of physical restraint and who can provide evidence of a semi-annual DJS approved refresher training on the appropriate use of physical restraint may implement physical restraint. At the end of 2007, all staff had completed CPM as required.

RECOMMENDATIONS

In order to reach Performance status, it is recommended that the facility:

- Provide refresher training to ensure staff are up to date on CPM and Report Writing training requirements. Require any staff that is past the six month CPM refresher period sign up for training immediately and follow up to ensure attendance.
- To keep CPM techniques fresh after training, regularly quiz staff and ask them to demonstrate restraints for Shift Commanders and Senior Management. Observe techniques and provide on-the-spot coaching.
- Encourage more videotaping of incidents. Consider a 30 day period of time where incidents without videotapes will require more feedback from staff directly to the Superintendent to explain the reason.
- Remind staff of their responsibilities to immediately intervene in the case of a fight. Identify staff who do not appropriately intervene through viewing video of incidents and document progressive discipline if staff do not respond as required.
- Consider joint trainings with other less experienced DJS staff persons from other facilities to share techniques for de-escalation of volatile youth.

CONTRABAND & ROOM SEARCHES — RATING: Performance

STANDARD
Written policy, procedure and practice document searches of rooms, youth and any contraband found. Incident Reports are written for contraband found in accordance with DJS policy.

SOURCES OF INFORMATION
Unit Logbook
Facility shakedown sheets
Interview with Superintendent
Observation at facility

REFERENCES
DJS Searches Policy (RF-06-07); Incident Reporting policy (MGMT-03-07); ACA 1-SJD-3A-16

SUMMARY OF FINDINGS

DJS policy requires youth rooms to be searched a minimum of once per week. Policy also requires that all general areas are searched to include the school, cafeteria, medical, and dayroom. These and other searches ensure the safety of both staff and youth. Though contraband will often enter a facility by many means, there should be assurances that staff are trained to look for it and that they properly handle it when it is discovered.

Incident reports were on file for contraband and comported with the DJS Incident Reporting policy. In fact, in one report from March 23rd, a youth told a staff person that another youth had cigarettes in his possession. This shows a trusting relationship between youth and staff that is admirable. There was good information from the narrative to show what occurred and a note was on the file to attempt to find out where the cigarettes had come from.

Upon observation, the facility cottages were clean and free of contraband, especially Cornish. After a shakedown, only one rated R movie was found on Rennie cottage along with some small trash items between chairs, nothing else. The facility shakedown sheets adequately described what was found and were dated.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Review IRs completed in the past several months to discover where contraband is most typically found on the units (Is it in vents? Under stairs or under

mattresses?) Use this information to alert staff to spend extra time in these areas when they conduct searches.

- Discuss contraband at bi-weekly self-assessment meetings.
- Ensure only G, PG or PG-13 movies are on the units.

SECLUSION	RATING: Partial Performance

STANDARD

Written policy, practice and procedure provide that youth confined to a locked room, not during sleeping hours, shall be observed often and have those observations documented, shall only be placed in seclusion if they present an imminent threat to others, a substantial destruction to property or an imminent threat of escape, and shall be treated humanely and with concern and care so as to safely maintain the youth until he can be released in the least amount of time.

SOURCES OF INFORMATON

- Facility Seclusion Log
- Seclusion Observation forms Feb-Apr 2008
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES:

DJS Seclusion Policy RF-01-07; COMAR 16.18.02

SUMMARY OF FINDINGS

DJS policy authorizes the use of seclusion only when youth present an imminent threat to self or others, are an imminent escape risk, or when less restrictive measures of control have not been successful. Seclusion cannot be used as punishment and must be documented according to policy. There is no prescribed length of time in seclusion due to its lack of a punishment aspect, but policy is clear that at certain intervals, youth either must be re-assessed, checked by mental health, documentation prepared as to extensions or (as is the case after 72 hours) released altogether.

Seclusion documentation indicates that seclusions at Cheltenham are short and rare. Indeed only three seclusion episodes were produced and logged in (all involving the same youth but on three different days). However, youth and staff alike indicated in interviews that "early bed" was common at the facility. Of the 15 youth interviewed (and none was the youth in the three recorded seclusion episodes), 10 indicated there was early bed and one indicated it could start before 6pm. At least 4 of 11 staff persons indicated there was early bed, and the earliest time given by staff was 6:30pm.

There was an effort made to see if there was one unit where "early bed" was given more than in others. But after reviewing the cottage assignments of the youth interviewed, there were no particular units where this seemed more likely to occur than not; answers of "yes" to the early bed question were given from youth and staff on all units throughout the facility.

The use of "early bed" is tantamount to seclusion. The youth is in his room during waking hours and when this is done, all procedures regarding seclusion must then be followed. No seclusion sheets were produced for any of the youth interviewed and nothing was noted in the seclusion log. The concern of the QI Team is that the facility is managing its seclusion numbers by using early bed as a punishment, but not documenting that practice as required. This issue has been visited in the past and a memo in 2007 was generated by the Assistant Secretary for Residential Services that the practice should cease. It seems to have made a resurgence if the youth and staff information is to be believed.

In a conversation with the Superintendent days after the review about this information, he indicated that this was not going to continue. He noted that both the youth and the staff would be made fully aware that there is to be no "early bed" at Cheltenham, and in fact on April 30th, shift commanders and case managers met with both youth and staff about this. In addition, a Directive was issued prohibiting early bed. The Superintendent plans on reviewing this daily at shift briefings and his case managers will review with the youth daily to ensure compliance.

Of the three episodes of seclusion documented, 2 of the 3 documented checks randomly six times per hour as required by policy. One had a time gap between 8:49pm and 12:48am. In one of the three, the shift commander's comments did not indicate why the youth was not being released. Shift commanders are required by departmental policy to meet with the youth in the first hour, and every two hours thereafter until release. The purpose is to discuss alternative behaviors and to assess readiness for release from seclusion and reintegration with the general population. This shift commander simply wrote that the youth "has to calm down, incident gang-related" but doesn't say what he was actually doing (banging on his bed, throwing food?) The second check indicated the youth was "showering" but again, he was not released. In one of the better sheets, the youth was "speaking to Mental Health," which is a good indicator the clinicians are a part of the seclusion process.

Two of the fifteen youth interviewed answered that they were placed in seclusion after a fight but there was no record of these at the facility. This is a small number (just 13%), and the youth may not have known the difference between being in a room alone with a door cracked or locked, but care should be exercised that staff are not locking youth in their rooms and not documenting that they are doing so.

Medical checks are required to be made of youth in seclusion every two hours according to policy. Of the three episodes reviewed, in two the medical checks were reliably made. In one, the nurse missed two checks; the youth was in seclusion for five hours.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Review seclusion paperwork daily so that staff and managers are aware of all seclusion-related documentation abnormalities immediately.
- Individually process with youth in seclusion and release each when the youth no longer presents a threat of harm or escape. Require that shift commanders processing with youth document exactly why a youth is not being released from seclusion every two hours on the seclusion observation form.
- Require shift commanders to contact the nurses when they see Medical has not completed their two hour check timely.
- Immediately discontinue the practice of "early bed" and require staff to only put youth in their rooms according to the Level System (8pm is the earliest bedtime for Level I youth.) If youth are in their rooms earlier than 8pm, use a seclusion observation form, log it into the seclusion log and require checks per policy and shift commander and medical checks as well. Remind staff that youth in their rooms without supervision are at highest risk for self-harm.
- Within 45-60 days after the April 30th meeting and Directive on early bed, survey youth to see if that practice has indeed ended. The QI Team can assist if requested.

ROOM CHECKS DURING SLEEP PERIOD	RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that staff visually check the safety and security of each youth at least every 30 minutes during the sleep period, unless instructed to check more often due to the status of the youth. Room checks during sleep period document the youth's name and the time the check was conducted

SOURCES OF INFORMATION

- Interviews with staff
- Logbooks
- Room check sheets
- Guard Tour documentation

REFERENCES

DJS Youth Movement and Counts Policy RF-02-06; ACA 3-JDF-3A-04 and 3-JTS-3A-04; Cheltenham's FOP (Room Checks) dated January 16, 2008.

SUMMARY OF FINDINGS

Room checks of youth after bedtime are vital to ensure the safety of youth. Not only does this ensure the youth is still where he should be throughout the night, but it ensures that youth who might want to harm themselves are not left for extended periods of time unobserved. DJS policy requires that staff conduct a room check of each youth during sleep periods at least every 30 minutes. Cheltenham's Facility's Operating Procedure (FOP) requires a visual room check of youth every 15 minutes and the documentation of that check to be done either electronically or manually (i.e. the Guard Tour system or Sleep Observation Sheet).

Interviews with the Director of Group Life and staff revealed that during January and February 2008, staff conducted room checks at 15 minute increments and documented the check on the Sleep Observation Sheets. After this time, the Guard Tour electronic system was installed and used instead of paper sheets.

A review of randomly selected Sleep Observation Sheets for the period of January 25 to February 3, 2008 revealed that room checks were documented at 15 minute increments. However, the documented times on the Sleep Observation Sheets are preprinted (i.e. 8:00; 8:15; 8:30; 8:45; etc). Since room checks should accurately reflect the exact time that a youth and room was checked, Sleep Observation Sheets with pre-printed times are not suitable for recording the exact time of the observations.

In February 2008, the facility initiated the use of the Guard Tour system and discontinued the use of the Sleep Observation sheets. A review of randomly selected data from the Guard Tour system from February 24, 2008 thru March 2, 2008 and March 23 thru April

3, 2008 was reviewed to determine the level of compliance with documenting room check procedures using this system. Among problems noted were:

- On one occasion, staff terminated several room checks 60 to 90 minutes prior to the youth wake up time.
- On several occasions staff did not consistently document the observation made of youth, but only identified the staff that performed the room check (i.e. on 2/24/08 and 2/25/08, Rennie cottage, staff during the 3rd shift was identified but the observed behavior of the youth were not consistently documented.)
- On other occasions, the time of a room check times was not staggered in accordance with the start time of a youth's scheduled bedtime (i.e. level I youth prepare for bedtime at 8:00pm, but documentation of room checks did not commence until approximately 10:00pm.).
- On several occasions, staff (Cornish cottage) for several hours (overnight) recorded "Youth in room on Seclusion eating meal" (i.e. On February 26, 2008, 10:18pm to 5:52am, the vast majority of room checks indicated: "Youth in room on Seclusion eating meal."

The recording of accurate observations made of youth behaviors during sleep periods is necessary to ensure the safety and strict accountability of youth. Staff should be more careful about selecting the appropriate code for the youth's activity.

The FOP requirement that visual room checks be documented at 15 minute increments is frequently exceeded by several minutes or longer. The majority of room checks, however, were conducted within the 30 minute increment as prescribed by DJS policy. There were several instances when the 30 minute increment exceeded 60 or more minutes but did not appear to be habitual in occurrence.

Based on an interview with the Director of Group Life, the facility currently downloads data from the Guard Tour system daily; however, the data is not uploaded for review on a daily basis. Therefore, discrepancies are not promptly detected and addressed, so that appropriate action can be taken. No documentation regarding disciplinary matters was available for review.

The Facility Operating Procedure (FOP) requires staff document the beginning of room checks in the unit logbook; the logbook entry shall reflect the time the room checks began, the name(s) of staff completing the room checks, and any problems occurring during the night. A review of randomly selected dates from unit log books for the period of January 25 to April 10, 2008; reveal that this information is not consistently documented in the log books as required by the FOP.

The FOP does not delineate a back-up plan should staff experience a problem documenting room checks with the Guard Tour system. Based on an interview with the Director of Group Life, staff would revert to using the Sleep Observation Sheets until the problem is corrected. This should be written and understood by all staff.

Also, the Superintendent noted that staff who inconsistently used the Guard Tour system would have to go back to also using paper sheets until they improved. Since the sheets are prone to falsification if a staff misses a check, and since Guard Tour cannot be falsified, it would be recommended they are required to use, and use correctly and consistently, the Guard Tour wands only and that their performance be scrutinized until acceptable.

RECOMMENDATIONS

In order to reach Superior Performance status in this area, it is recommended that the facility:

- Update the facility operating procedure (FOP) to include a daily review of the Guard Tour data and what to do in case of a computer or wand malfunction.
- Verify via the Shift Commanders that staff are recording/documenting accurate observations of youth.
- Forward all discrepancies and failures to meet the FOP requirements immediately to the Superintendent for follow-up and corrective action.
- Stop using the written Sleep Observation Sheets with pre-printed times.
- The actual time of each room check, the name(s) of staff completing the room checks, and any problems occurring during the night should be documented in the unit logbook and on the room check sheets, if in use.
- Require staff use only the Guard Tour system and not paper sheets unless there is a computer or wand malfunction. Document progressive discipline for staff who consistently miss room checks.

PERIMETER CHECKS	RATING: Performance

STANDARD

Written policy, procedure and practice document daily security checks of the perimeter to include, at a minimum: a check of all locks, windows, doors, fences, gates, security lighting, security devices, and a check of outdoor areas, gates and security fences to ensure they are secure, free from contraband and have not been tampered with.

SOURCES OF INFORMATION

Facility and Perimeter Tour
Observations
Logbooks
Guard Tour documentation
Interviews with Director of Group Life and staff

REFERENCES

DJS Perimeter Security Policy RF-09-07, Maryland Standards for Juvenile Detention Facilities; ACA 3-JDF-3A-12, 2G-02, 3-JTS-3A-12 and 2G-02, Cheltenham's FOP (Perimeter Checks) dated January 12, 2005.

SUMMARY OF FINDINGS

Regular perimeter checks are an important aspect of safe facility management. Fence breaches, unlocked doors and damaged gates can lead to escapes. DJS policy requires that searches of perimeter and grounds be conducted on a daily basis to ensure that there are no immediate breaches of security or visible contraband.

On March 10, 2008, the facility's Perimeter Checks standard was the subject of a targeted review for the period of December 1, 2007 to March 9, 2008. The targeted review resulted in a "Performance" rating.

During the week of April 22-25, 2008, the facility's Perimeter Check standard was reviewed for the period of March 10, 2008 to April 15, 2008. Based on interviews with a repair technician(s) and staff, the hardware required to correct the malfunctioning fence alarm sensors is currently in process. The repair work is expected to be completed by the end of April 2008.

Based on interviews with the Director of Group Life, staff and the Superintendent along with a review of the Tour Office's log book and the Guard Tour data, inspections of the perimeter are occurring on a daily basis. However, there are still occasions when a perimeter check is not conducted (i.e. April 4, 5, 6, and 7, 2008) due to inclement weather or staffing.

A small amount of leaves/debris was observed along the fence line in the rear area of Henry and Rennie cottages. Removal of the leave/debris would aid staff in locating any contraband during a visual inspection of the fence line.

The FOP (Perimeter Checks) is still in the process of being revised to reflect new perimeter check procedures (i.e. Guard Tour system).

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Complete the revision to the FOP regarding the new perimeter check procedures.
- Complete the repair work to the perimeter fence alarm system.
- Request that Maintenance remove any and all leaves/debris from along the fence line.
- Ensure via the Shift Commanders that perimeter checks are conducted every day.

STAFFING	RATING: Partial Performance

STANDARD
The facility maintains a current staffing plan that ensures a sufficient number of staff is present to provide an environment that is safe, secure and orderly.

SOURCES OF INFORMATION
- Facility staffing list including vacancies
- Facility Logbooks
- Shift schedules for six random days
- Interview with Superintendent
- Observation at facility

REFERENCES
ACA 1-SJD-1C-03

SUMMARY OF FINDINGS

Consistent coverage of facility shifts is vital to the safety and security of DJS youth. Only with enough well-trained staff can the youth be afforded solid supervision as well as access to education, programming and recreation. The staffing ratio at Cheltenham is 1:8. This ratio is within professionally accepted standards.

Observation at the facility showed that youth were being supervised within the 1:8 ratio established but it was sometimes unclear to staff what the ratio at Cheltenham was. For example, some staff at the Re-Direct program noted the ratio there was 1:9, and other staff noted it is 1:6. Most (82%) of staff noted the ratio was 1:8. Though 1:6 is even more ideal, it may be worthwhile advising staff that 1:8 is the acceptable standard so that all are on the same page.

Often, fragile youth on Guarded Care plans require 1-to-1 supervision. Though the facility is clear on who these youth are, it is not always noted in the logbook daily and staffing is certainly affected when a staff is with a 1-to-1 youth. Staff should take care to note this daily along with the staff person assigned to that youth.

A review of unit log books on random dates along with corresponding population sheets found one shift out of ratio on March 1st on Rennie and Henry cottages, one on March 25th on Rennie only and one shift on March 28th, also on Rennie. There may have been instances where the unit manager went into coverage to make up for the deficiency, but that fact was not noted in the log book. Without such a notation, it appeared these shifts were not in ratio. If they were in coverage, the ratios were met.

RECOMMENDATIONS

In order to reach Performance status, it is recommended that the facility:

- Hold Shift Commanders accountable for maintaining safe staffing ratios throughout the shift.
- Require that staff document all Guarded Care plan and 1-to-1 youth statuses in the logbook and who their assigned staff is every day.
- Require the staff to indicate in the log book when unit managers or shift commanders go into coverage to meet ratios.
- Ensure all staff and management are clear about the 1:8 ratio. Clarify if the Re-Direct program operates under a different ratio.

CONTROL OF KEYS, TOOLS & ENVIRONMENTAL WEAPONS	RATING: Non Performance

STANDARD

Written policy, procedure and practice provide for the control of tools and equipment that could be used as weapons or for other dangerous purposes. There is system that ensures strict accountability of the receipt, usage, storage, inventory, and removal of all toxic and caustic materials.

SOURCES OF INFORMATION

- Facility Tour
- Interview with staff
- Key Inventory
- Tool & Sharp Objects Inventory

REFEERENCES

DJS Key Control Policy RF-06-05; DJS Perimeter Security Policy RF-09-07, ACA 3-JDF-3A-22 and 3-JTS-3A-22

SUMMARY OF FINDINGS

KEYS:

DJS policy and the facility's FOP requires that all staff be provided with a metal key chit(s) stamped with the staff's name or assigned number that is exchanged for receipt of facility keys. At this Cheltenham, staff members are provided facility keys without the required metal chit (i.e. for the most part, facility keys are exchanged among unit staff at the beginning of each shift and documented in the unit log book). Dining Hall keys, however, are maintained at the gatehouse but there is no sign in/out procedure for the keys.

(Note: The facility does utilize a metal chit system in which staff and visitors exchange their vehicle key(s) for a metal chit (numbered) prior to entering the facility. From a security point of view, this procedure reduces the possibility of a youth gaining access to a vehicle, but does not provide a strict accountability for the exchange/receipt of facility keys.)

DJS policy requires that the key control officer conduct a random count of the number of keys on one key ring each working day and document the count in the facility's logbook, as well as maintain an inventory of the Back-up Key Board. Emergency keys are to be tested quarterly to ensure proper functioning. There was no documentation presented to verify that any of the aforementioned practices were conducted between January 1 and April 15, 2008.

DJS policy requires that facilities maintain a Working Key Board that contains keys issued on a regular basis, and a Back-up Key Board containing back-up and pattern keys which should be located in a secure location. The facility's Working Key Board is located in the key control officer's office and the Back-up keyboard is maintained in the Administration Building. The facility's FOP, however, indicates that the Working Key Board should be maintained at the Command Control Center (Tour Office) to facilitate the exchange of key chits and issuance/receipt for facility keys. There is a master key inventory list kept at the location of the Working Key Board.

The facility's FOP requires highly restricted keys be stored in a separate locked boxes. Highly restricted keys, however, are not stored in accordance with that FOP.

DJS policy requires that a set of emergency keys are maintained in a secure location away from, but near, the facility (either at another DJS facility, local law enforcement facility, fire station, etc.). Based on interviews with the key control officer and Superintendent, emergency keys are located at DJS Headquarters in Baltimore City which is a considerable distance from the facility, and at an hour's drive, is too far to be useful in the case of a true emergency.

TOOLS AND ENVIRONMENTAL WEAPONS:

Since the daily operation of the facility requires staff to have access to various tools, culinary, cleaning and medical equipment, a system of internal accountability should be maintained in order to always account for these items so as to maintain facility safety.

On two occasions in Rennie cottage, the laundry room door was observed unlocked. The laundry room contained several containers of detergent that could possibly harm a youth if digested. Cleaning solutions were also observed sitting out on a desk in the unit. The solutions were removed after being brought to the attention of staff.

The Maintenance shop does not maintain a master inventory list of tools and equipment at the facility. There is no sign-in/out system for tools and equipment maintained to identify or track who obtained the items.

The Health Center maintains a perpetual inventory system that tracks the number of hypodermic needles used and stored. However, some hypodermic needles were stored in a plastic container while others were stored in a locked metal box. Since the hypodermic needles are all kept in a room adjacent to an exam room used for youth, they should be secured in a locked container.

The Dining Hall does have an inventory system that accounts for the storage of knives/utensils, however, there is currently no sign/out system maintained to identify or track who may have retrieved the items. One is highly recommended.

RECOMMENDATIONS

In order to reach Performance status in this area the following is recommended:

- Adhere to the Department's Key Control and FOP (Key control) policy.
- Assign chits to all employees. These chits should be used for the retrieval and return of keys.
- Relocate emergency keys to a location closer to the facility.
- Write a FOP for the control and inventory of Tools/Environmental Weapons.
- Establish a sign in/out system to track the use of all Tools/Environmental Weapons at all locations throughout the facility.

YOUTH MOVEMENT & COUNTS — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document a system for physically counting youth. Youth movement is orderly and provides for identifying each youth movement and the specific location of each youth at all times. Formal and informal headcounts are conducted and documented in accordance with departmental guidelines. Emergency counts are conducted and documented when necessary.

SOURCES OF INFORMATION

- Logbooks
- Interviews with staff
- Interviews with youth
- Facility tour
- Observation of youth movement

REFERENCES

DJS Youth Movement and Counts policy RF-02-06; ACA 3-JDF-3A-13 & 14 and 3-JTS-3A-13 & 14

SUMMARY OF FINDINGS

Based on interviews with staff, along with observations of youth movement and a review of Tour office and unit logbooks, youth movement is generally orderly and is consistent with the 1:8 staff to student ratio.

The facility conducts head counts multiple times throughout the day. However the documentation is not done according to DJS policy. Currently, unit logbooks basically note the time and count. DJS policy requires that counts be recorded in unit logbooks to include not just the time and count, but also:

- Name(s) of employees performing the count;
- The location of groups of youth (library, class, outside area); and
- Youth outside of the location where the count is occurring.

Without this relevant information included in each documented headcount, it is not possible to determine if the counts accurately reflect the actual number of youth and staff present. Proper headcount documentation is essential to ensure a strict accountability of youth at all times.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Train staff on the proper documentation procedure of head counts.
- Review the logbooks via the Unit Managers and Shift Commanders and address deficiencies daily with unit staff.

FIRE SAFETY	RATING: Superior Performance

STANDARD

Written policy, procedure and practice document the facility's fire prevention and safety precautions in accordance with departmental guidelines. Provisions for adequate fire protection service provide for the availability of fire protection equipment at appropriate locations throughout the facility and the control of all use and storage of flammable, toxic, and caustic materials.

SOURCES OF INFORMATION

- Facility Tour
- Interviews staff
- Interviews with the Superintendent
- Interviews with maintenance staff
- Review of Logbooks
- Examination of Fire Safety Equipment
- Fire Drill Documentation

REFERENCES

DJS Policy MGMT-3-01; ACA 3-JDF-3B-05, ACA 3-JDF-3B-10 and 3-JTS-3B-11

SUMMARY OF FINDINGS

Clear fire safety procedures, regular fire drills and maintained fire equipment are necessary to ensure the safety of the youth and staff at any facility and are also required by Maryland Code.

Based on a review of the Maryland State Fire Marshal's report, Fire Alarm System maintenance records, sprinkler system inspection records , facility maintenance records, fire drill records and interviews with Cheltenham's superintendent, fire safety officer, staff and youth, this facility is solidly adhering to fire safety procedures. Fire drills are conducted properly and timely, units are sprinklered if they sleep youth overnight, and the fire safety office is extremely knowledgeable about fire safety practices within the facility.

During a tour of the facility, a randomly selected staff member was able to unlock and open a fire exit door without having to look at the key. The staff stated that the key is marked/notched in a manner that readily identifies it as a key to an exit door, making it identifiable during a smoke filled environment or other emergency situation.

Staff did have difficultly unlocking and removing several locks on the gates to the fenced-in recreation yards behind the units. The locks had been placed backwards on the gates making it difficult to unlock and remove the lock. These gates provide a means of egress from the recreation yard in case of an emergency, though youth could clearly be outside and out of immediate danger. The fire safety officer indicated that the locks will

be marked to indicate the proper position they should face when placed on the gate in the future.

Three small additional observations were noted:

- A small swell in the ground prevented the gate of one unit's recreation yard from opening easily.
- Picnic tables blocked the gate of two units. The tables were removed.
- On Rennie cottage, the fire extinguisher box at the entrance to the gym and at the end of the hallway does not contain a lock.

RECOMMENDATIONS

The facility is in Superior Performance status. Three small recommendations are made:

- Ensure that gates are not blocked by tables or any other items and that they are routinely opened to check for proper functioning.
- Install locks on all fire extinguisher boxes located on units.
- Ensure all of the units' recreation gates easily open. If they do not, ask Maintenance to level the ground so that they can be easily opened.

POST ORDERS	RATING: Partial Performance

STANDARD:
Written policy, procedure, and practice provide post order for security post and key staff positions. Staff members are familiar with roles and responsibilities of the post order prior to assuming the post. Post orders are current. Shift commanders ensure that post orders are reviewed by the staff member. Post order signature sheet is signed by the staff assuming the post and initial by the immediate supervisor.

SOURCES OF INFORMATION:
Logbooks
Facility Tour & Observation

REFERENCES:
DJS Post Orders Policy RF-07-07; ACA 3-JDF-05, 3-JDF-3A-06, 3A-JDF-3A-07

SUMMARY OF FINDINGS:

A post is a place or function to which security staff members are assigned to ensure a safe, secure and orderly environment. Post orders are a written set of instructions, requirements, and guidelines for security staff to follow to ensure the effective operation of an assigned post to promote the safety and security of the facility, youth, and staff.

DJS policy states that at a minimum Post Orders shall be established for the following staff positions: (a) Resident Advisor (b) Resident Advisor Lead, (c) Resident Advisor Supervisor, (d) Shift Commander (e) Security; and (f) Special duty/assignment positions (i.e. key control, supply, safety officer or emergency management officer). This facility does not have post orders exclusively for the positions of: (a) Resident Advisor and (b) Resident Advisor Lead; however, information relative to the positions is included in the facility's Housing Staff post order.

The facility currently has 9 post orders: (1) Housing Staff, (2) Shift Commander, (3) Unit Manager (Pod Manager), (4) Tour Coordinator (5) School Supervisor, (6) Pedestrian Gate Operator, (7) Visitation Monitor, (8) Transportation Staff, and (9) Security Officer. All of the post orders are signed and dated May 29, 2005, with the exception of the Unit Manager post order which in not signed or dated. DJS policy requires that all post orders include a last review date and the next review date. None of the post orders contained a last reviewed and next review date.

DJS policy requires that a copy of each Post Order and Post Order Signature form be maintained on or near each post and at the Command Control Center/Master Control. A random check revealed that a copy of the facility's post orders was maintained in the Tour Office and school, but that there were no signed post order signature forms available for review.

It is recommended that the facility write post orders for the following applicable posts as reflected in the DJS Post Order Policy:

- Admissions
- Health Services Unit
- Dining area
- Laundry
- Maintenance Shop
- Fire safety officer

RECOMMENDATIONS

In order to reach Performance status in this area, it is recommended that the facility:

- Ensure that staff review and sign the Post Order Signature form.
- Post a copy of all signed Post Order Signature Sheet(s) on or near each post as required by DJS policy.
- Post orders should be written for the applicable posts noted in the body of this report, revised as needed and reviewed at least annually.

STAFF TRAINING — RATING: Partial Performance

STANDARD

Written policy, procedure and practice provide that all full-time staff who have regular and daily contact with juveniles receive organized, planned and evaluated trainings in accordance with departmental guidelines. Training is designed to develop the employee in job specific learning objectives.

SOURCES OF INFORMATION

- Discussion with the Superintendent
- Facility training spreadsheet records
- OPDT training records

REFERENCES

Maryland Correctional Training Commission (MCTC); ACA 1-SDJ-1D-03, ACA 3-JDF-1-D-01, ACA-JDF-1D-02

SUMMARY OF FINDINGS

Department policy requires that employees in Case Management, Residential Advisor and all other mandated positions participate in at least 40 hours of in-service training annually in order to remain in compliance with DJS policy requirements. CYF currently has 133 employees in residential care positions; of these, nearly all are merit employees and 26 are contractual employees.

Twelve staff at CYF were interviewed and seven (7) of the twelve reported that they had completed the Department's Crisis Prevention Management (CPM) training within the past three months; the other four indicated that they had last completed the training in September or October 2007. Certification numbers are as follows:

Of the staff hired prior to December 1, 2007, 8 are not provisionally certified. Of the 18 staff hired after December 1, 2007, 15 are not provisionally certified. This means that of the 133 filled positions at CYF, 23 staff (17%) are not certified

Of the 23 staff who are not provisionally certified:
- 14 have successfully completed ELT
- 5 have not successfully completed ELT
- 3 are currently in ELT
- 1 is scheduled to begin ELT in July

Training schedules for April '08 thru June '08 were submitted to the QI team that indicated that training sessions (i.e. CPM, report writing, adolescent mental health, DJS standards of conduct, child abuse, verbal de-escalation, suicide prevention, standard first aid, and gang awareness) have been scheduled for nearly every day of this time period and that CYF is making diligent efforts to provide all required trainings.

RECOMMENDATIONS

In order to reach Performance status, it is recommended that the facility:

- Adhere to the in-service training schedule that has been developed to ensure that staff meet the requirements for annual in-service training. Provide the list of staff that will attend each phase of the in-service training to OPDT.
- Develop an internal audit system to check staff records for training deficiencies in order to "catch" the training hour deficiencies before they become overwhelming. Consider requiring monthly updates on status to the Superintendent.
- Ensure all staff are certified or are scheduled for classes they may be needing and in all cases, ensure staff who are not MCTC-certified and have not had the required CPM classes are not working with or using physical restraints on youth.

ADMISSIONS, INTAKE & STUDENT HANDBOOK	RATING: Performance

STANDARD

Written policy, procedure, and practice provide that the admissions process in each detention is operated on a 24 hour basis. The admissions process documents all required elements of the admissions. Such required elements include the initial search of the youth, verification of legal status, verification of basic identifying information, search of ASSIST database to obtain all legal history, photograph of youth upon admission, telephone call, classification, identification, student handbook, clothing and state issued items, and movement to the unit.

SOURCES OF INFORMATION

- Observation
- Review of the Facility Intake Packet
- Review of Facility Handbook
- Interview with Intake staff
- Interviews with youth

REFERENCES:

Admissions and Orientation Policy RF-03-07; Maryland Standards for Juvenile Detention Facilities; DJS Classification Policy in editing stage; ACA 3-JDF-5A-02, 3-JTS-5A-01, 5B-01 through 04 and 5B-07 & 08

SUMMARY OF FINDINGS

An orderly and consistent intake process ensures youth who enter Cheltenham do so fully screened and with information they need in order to know the rules of the facility. Interviews and documentation showed a procedure, including a search, issuance of clothing and allowance of a phone call, is in place to move youth from intake into the general population in a structured and consistent way. There is an Intake Orientation pamphlet as well as a Youth Advocacy pamphlet given to each youth at intake into the facility. These contain the basic rules and the grievance process. A full handbook is given to youth during Orientation. A quiz is given to Orientation youth to be sure they understand the rules of the facility and the Team found this to be a positive addition to the Orientation process.

Having a youth handbook is good practice, not only because it is required to be available by policy, but also because it is an excellent method for clarifying issues. Referencing the same handbook puts both the youth and staff "on the same page," often helping youth understand that staff are also required to follow certain rules regarding youth movement and bedtimes; it also lets the youth know what is and is not acceptable on the unit. Handbooks also help remind the boys of who key personnel are throughout the facility should they have a question.

The handbook at Cheltenham that the QI Team was presented with is an old version and incomplete. A new version was sent in December 2007 with updated information. The new version will be emailed to the Superintendent again, as the old version had a myriad of problems such as: the Assistant Superintendent's name on the front and on page 5 is outdated; many pages are "cut off" at the top from frequent copying and information is therefore impossible to read; on the bottom of the third page, Child Advocate should be changed to Youth Advocate to reflect DJS' change in this unit's name; many of the names of key personnel on page 5 are outdated; and the BMP point deductions are not accurate with the facility's current BMP. It should also be noted that about half of the youth interviewed noted they did not receive a handbook upon entry.

Youth upon entry are to be screened using the FIRRST Health Care Screening. The intake staff person indicated properly that youth who screened positive on the FIRRST were not to be admitted and were sent back with the police for hospitalization or evaluation. A review of 11 youth base files by the QI Team found that all youth had an updated copy of the FIRRST in their file. Youth also are required to undergo MAYSI and SASSI screenings within two hours of admission. Again, the intake staff person was aware of this and specifically indicated they had to be completed within two hours. Ten of eleven base files had a current copy of the SASSI in the file. MAYSIs were filed in the medical charts and were assessed by the Behavioral Health QI Reviewer (see Behavioral Health and Suicide sections of this report.) Current photographs are also taken of all youth as required and evidence was present of this in the files.

Finally, a "face sheet" with the youth's information and a true or false "rules quiz" are completed and given to Orientation youth and filed. All youth files had a face sheet and 10 of 11 had a completed and scored quiz. These are all excellent levels of compliance.

RECOMMENDATIONS

In order to reach Superior Performance status, the following is recommended:

- Ensure that only the updated handbook is used and that all youth have a copy of it. Destroy all versions of the old handbook and remind Intake and Orientation staff not to use any paper or electronic versions of the old handbook; send the updated version to staff electronically as well.

CLASSIFICATION	RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that all youth are classified and assigned housing according to current age, severity of current legal charge, most serious prior charge, number of prior serious incidents while in custody and special needs. FOP and practice also provide for reassessment of all youth no later than 60 days following facility admission and within 24 hours of the third serious incident since admission to the facility, and more frequently in response to needs of youth or security of the facility.

SOURCES OF INFORMATION

- Interview with Superintendent
- Interviews with Admissions/Intake Staff
- Review of Intake Packet
- Review of DJS Classification tool in editing stage
- Observation at facility

REFERENCES

Maryland Standards for Juvenile Detention Facilities; DJS Classification Policy in editing stage; ACA 3-JDF-5A-02, 3-JTS-5A-01, 5B-01 through 04 and 5B-07 & 08;

SUMMARY OF FINDINGS

Properly classifying and housing youth prevents young or vulnerable youth from being housed with or near older, more aggressive youth. Based on the layout of Cheltenham, youth can be classified into several different cottages based on age, aggressive history, medical or mental health status and legal status.

In reviewing the Intake Packet and in speaking with the Intake staff person, it was evident that the basics are being attended to. Youth who are medically or mentally fragile go to the Health Center, young 13 and 14 year old boys are assigned to Cornish, 15 and 16 year olds (and smaller 17 year olds) reside on Henry cottage and the most aggressive, older youth (17-19 years) are assigned to Rennie cottage. Grouping youth by age, size and aggression are all sound practices for classifying detention youth; there was no indication youth who need higher levels of supervision are housed in actual sleeping rooms that are closer to staff, however, as is ideal.

Though in the packet it was clear that the new Classification tool was present, it was also being revised by DJS the week of the review, so proper classification using that tool was not reviewed by the QI Team.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Use the new policy and instrument, when the DJS Classification policy and tool are enacted, to ensure youth are housed properly for safety. Write an FOP to follow up on expected staff practice.
- Ensure the tool is also used to identify youth whose rooms should be closer to staff for increased levels of supervision.
- Track the success of this effort to see if any changes in classification are benefiting the facility and its incident levels or locations. Consider discussion of this in the self-assessment meetings.

PENDING PLACEMENT RATING: Performance

STANDARD

Written policy, procedure and practice document that the facility has a list of youth pending placement, their days committed, and average length of stay and aggressively prioritizes these youth in order to assist the community case managers in placing them as quickly as possible in order to reduce time in detention.

SOURCES OF INFORMATION

- Discussion with the Superintendent
- Facility Population/Pending Placement List
- Interviews with youth
- ASSIST database

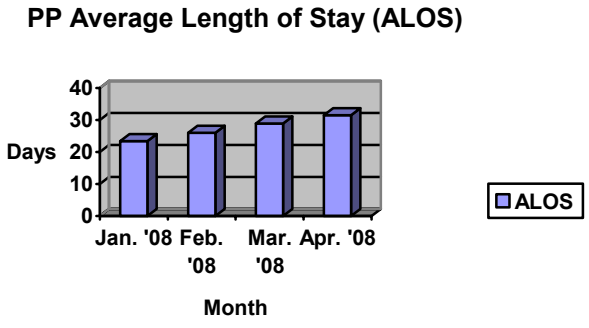
REFERENCES

Maryland Standards for Juvenile Detention Facilities, ACA 3-JDF-5H-01, 3JDF-3E; DJS Detention and Shelter Care Policy, SD – E2220-01-01

SUMMARY OF FINDINGS

Detention is limited to "those youth who pose a risk to public safety" and shelter care is limited to "those youth who require temporary out of home placement for their personal safety, or because there is no parent, guardian, custodian or other responsible person available to provide twenty-four hour supervision and care for a youth and to guarantee a youth's return to a court when required."

Over the course of the months observed, Cheltenham's daily population averages have been on the rise (Jan. – 96.7; Feb. – 99.2; Mar. – 112.6; Apr. - 119.1) which in turn could be linked to the average length of stay (ALOS) for the pending placement population that is displayed in the chart below.



Of the fifteen randomly selected youth interviewed, the average length of stay for the seven (7) youth who were pending placement was 60 days. Interviews with the Superintendent revealed evidence that the team of staff at the facility does in fact consider the pending placement population to be a top priority. They have weekly treatment service plan meetings and detention review meetings are held each Wednesday for those youth pending placement. In January there were a total of 213 admissions into CYF, of them, only seven (7) were youth who had been pending placement for thirty days or more. Additionally, from January thru April '08 there was only one youth pending placement beyond ninety days. This youth had been in multiple placements prior to CYF; nevertheless, he transitioned to his placement by February '08.

RECOMMENDATIONS

In order to reach Superior Performance, it is recommended that the facility:

- Continue to place a priority on transitioning the pending placement population out of the facility through treatment service plan meetings and detention review meetings. Additionally, the facility may want to consider reaching out to the prospective placements of the youth once they have been identified. In doing this, information can be shared by both parties and the facility's advocacy may expedite the placement process.

BEHAVIOR MANAGEMENT — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document a behavior management system which provides a system of rewards, privileges and consequences to encourage youth to fulfill facility expectations and teach youth alternative pro-social behavior.

SOURCES OF INFORMATION

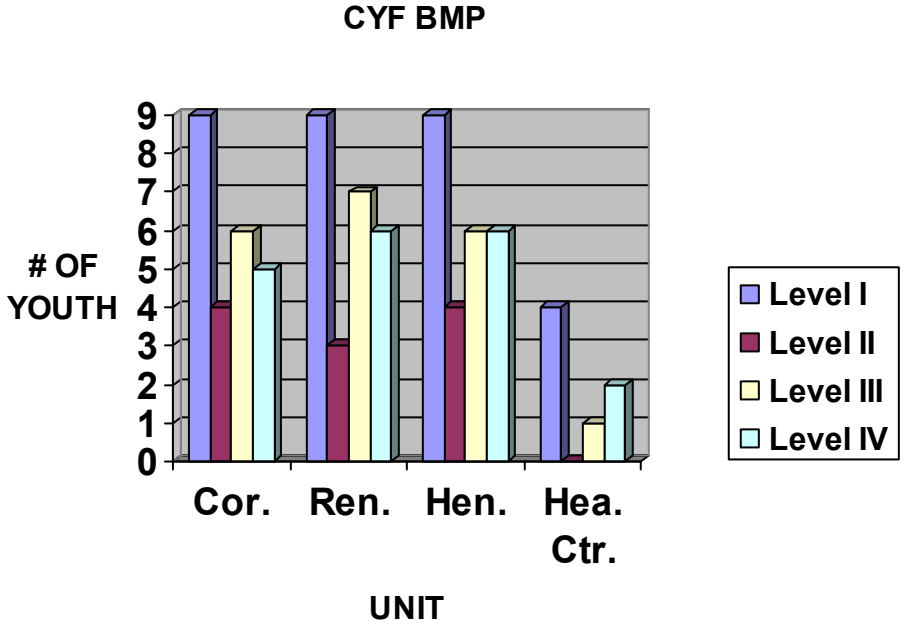
- Unit Log Books for all housing units
- Daily Point Sheets
- Unit Point Sheets
- Interviews with youth
- Interviews with staff
- Observations on housing units

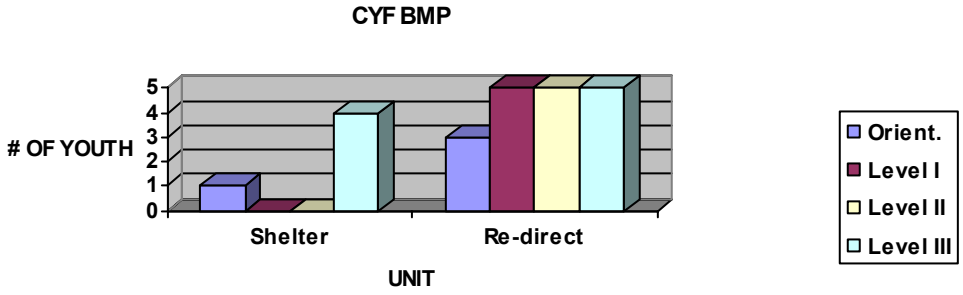
REFERENCES

DJS Behavior Management Program Policy RF-10-07; Facility Behavior Management Program (BMP)

SUMMARY OF FINDINGS

CYF has four (4) detention units (Cornish, Rennie, Henry, and Health Center), a shelter program, as well as a Re-Direct short-term committed program. The BMP for the detention program allows for youth to progress through four levels (Level I thru Level IV); the shelter and Re-Direct programs have Orientation thru Level III.





The QI team found that both staff and youth had a good understanding of how the BMP worked; this information was revealed in the twelve staff and fifteen youth interviews. The facility has adopted a practice of posting the actual BMP on each housing unit to serve as a guide for both staff and youth to follow with regards to the BMP. This appears to be working in that after reviewing point sheets that included explanations for deductions, there were no instances observed where staff were deducting more points than the system allowed for. The youth stated that staff were almost always fair and consistent when deducting points and that there was a grievance or appeals process available for them if needed. There were no deficiencies observed with documentation from both the shelter and Re-Direct programs.

There were some small concerns: the other four (4) detention units did not have any consistency in whether a youth could end the day with zero points or if they could actually go into negative numbers. Discussions with the Superintendent revealed that if more points are deducted than the youth actually has accumulated, the youth should be ending the day with zero points; negative integers should not be carried over to the next day. Additionally, Cornish had 39 instances where explanations were not being provided as to why youth were being deducted points or being awarded bonus points. Finally, documentation from the Health Center revealed that in 31 instances, youth were not eligible for the 100 daily points outlined in the facility BMP. Explanations were written as to why they did not receive the 100 points, such as half school days or no recreation due to inclement weather, but the youth must be given their points for the things they are doing (instead of school or recreation) on these days in order for the program to be fair and to work.

RECOMMENDATIONS

In order to reach Performance, it is recommended that the facility:

- Ensure youth point sheets reflect positive numbers or zero at the end of the day; youth should not be beginning the day with negative integers. The facility's BMP should be clearly written to reflect this information.
- Ensure unit point sheets always provide explanations as to why youth are having points deducted and why bonus points are being awarded.
- Youth should always be eligible for the 100 daily points regardless of schedule changes; the facility BMP should be updated to reflect this information. A memo from the Superintendent reiterating this is also a good idea.

STRUCTURED REHABILITATIVE PROGRAMMING	RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that youth receive planned, structured outdoor and indoor activities and regular rehabilitative programming that teaches social skills.

SOURCES OF INFORMATION

- Review of 24-Hour Unit Schedules
- Interviews with youth
- OIA Youth Advocacy February 2008 Report
- Interviews with staff
- Interview with Superintendent

REFERENCES

DJS Recreational Activities Policy RF-08-07; ACA 3-JDF-5E-01-02-03-04

SUMMARY OF FINDINGS

Meaningful and structured programming is a vital part of any detention and treatment facility. Youth who are constantly engaged in social and other skill development are less likely to be involved in incidents and more likely to benefit from the skill-building this programming is intended to convey.

On March 10, 2008, and April 9, 2008, the facility's Structured Programming standard was the subject of a targeted review for the period of December 1, 2007 to March 9, 2008. The targeted review resulted in a "Partial Performance" rating. Since that last targeted review, the facility has posted new daily and weekend schedules on each unit.

The facility is in the process of implementing several new programs to positively influence youth behavior. Based on interviews with staff, along with an observation of a new program, it appears that youth appreciate the new programming. Youth seemed engaged and interested. The unit youth attended the program in two groups.

The focus groups from the OIA Youth Advocacy Unit report revealed that youth enjoyed several of the activities that were occurring at the facility and looked forward to future activities. Since the new programs have just been added to the programming schedule, it is too soon to evaluate them effectively. Therefore, the rating for this standard will remain in partial performance until the programs can be properly evaluated.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Continue encouraging more programming. Ensure vendors are clear about expectations and that they feel welcome and want to continue providing services.
- Have QI conduct a targeted review of the structured programming standard after the new programs have been implemented for at least 60 days.

SELF ASSESSMENT — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that the facility superintendent at least twice monthly meets with his or her management staff to assess the facility's status involving the use of seclusion, restraints, incident reporting numbers and procedures and other key area of facility operation in order to assess the facility's compliance with DJS norms and expectations.

SOURCES OF INFORMATION

- Interview with Superintendent
- Attendance at daily management meeting on 4/28/08
- Review of Incident Report Statistics

REFERENCES

None (DJS QI Policy in development)

SUMMARY OF FINDINGS

Self Assessment is a relatively new process for DJS facilities. Its function is to assess the critical indicators within each facility, including seclusion use, incident frequency, suicide watch numbers, and restraint use, as examples. Data to assess the effectiveness of key areas of facility operations is retrieved from DJS' Incident Database (e.g., frequency, time, location of restraints, seclusion, youth/youth assault and other critical incidents) and facility records (e.g., overtime, staffing patterns) The facility superintendent should lead a meeting at least every two weeks to ensure these crucial areas are examined.

Cheltenham's Superintendent holds daily management meetings and one was attended by this QI reviewer on April 28th. Good discussions were had about individual youth and it was clear there is solid communication between the areas of education, medical, behavioral health, and the administration. There was not a particular use of data from the OIA database or otherwise in this particular meeting.

RECOMMENDATIONS

In order to reach a Performance rating, it is recommended that the facility:

- Create a dated Self Assessment meeting agenda and include a sign in sheet of management staff attending. Keep a file of each agenda with the data indicators discussed that week along with staff sign-in sheets.
- Document a summary of the weekly discussion to discuss in daily management meetings to provide evidence that the data indicators are used in conversations with staff and to modify practices.

- Add secondary incident data to the statistical printout as the primary incident data alone often leaves out key information, such as restraints, that may change the picture of what is actually occurring at the facility.

BEHAVIORAL HEALTH

INTAKE, SCREENING, & ASSESSMENT RATING: Performance

STANDARD

Written policy, procedure, and practice require that all youth admitted to a facility will be screened by a qualified mental health professional in a timely manner using valid and reliable measures. All youth who screen positively for behavioral health issues will be referred for a full mental health assessment by a mental health professional. All youth who present at the facility with behavioral health issues that, as determined by professional mental health assessment, are beyond the scope of what the facility can safely treat, will be transferred to a setting that can more appropriately meet the youth's needs.

SOURCES OF INFORMATION

- Youth medical files
- Interview with the Superintendent
- Interviews with youth
- Interview with
- Unit daily schedules

REFERENCES

DJS Suicide Policy (HC-1-07)

SUMMARY OF FINDINGS

Many youth who enter DJS' detention facilities present with mental health and substance abuse needs that have been in the past undiagnosed and untreated. These behavioral problems, if left untreated, can lead to further substance abuse, delinquency, and violence. Because of that fact, it is vitally important that the opportunity to treat detained youth with mental health and substance abuse problems does not pass without positive action steps being taken to improve the lives of these young people in our care. Part of these action steps includes timely and appropriate screening of youth at intake.

Of seven medical charts reviewed, six had the MAYSI on file and four charts had the SASSI on file. None of these charts had the FIRRST on file but Cheltenham Youth Facility (CYF) keeps these initial screening documents in the youth's base file and that they were present in the base file when checked. It will be recommended that a copy also be placed in the medical chart so that medical and behavioral health personnel will have access to the youth's initial screening.

Suicide assessments were completed as part of the behavioral health evaluation. When further need was indicated, specific suicide assessments were done and appropriate suicide watch levels were assigned.

Mental health and substance abuse assessments were appropriately completed by qualified behavioral health staff. When indicated, youth were referred to the full-time psychiatrist, for a full Psychiatric Evaluation. When youth are found to have behavioral health issues that exceed the capacity of CYF, the youth are referred to one of two locations: if the youth needs immediate short term care, they are transported to Southern Maryland General Hospital. For youth that can tolerate a longer transport and are in need of extended evaluation and/or services, Spring Grove Hospital Center is used.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Ensure MAYSIs, SASSIs and FIRRST screening are not only in the youth's base file but are also included in the medical file, thus increasing the effectiveness and efficiency of communication and overall knowledge of the youth's initial presentation at the facility.

INFORMED CONSENT	RATING: Superior Performance

STANDARD

Written policy, procedure, and practice requires that youth, and when appropriate, their guardian, are informed of the risks, benefits, and side effects of medication and the potential consequences of stopping medication abruptly. Youth are also notified that their conversations with clinicians, though confidential, may be shared with DJS and the Court if requested.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Informed consent is a process of communication between a youth and clinician that results in the youth's authorization or agreement to undergo specific interventions. Informed consent means that the youth was given sufficient information to make a decision regarding his or her mental health care. In turn, the youth should have an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of intervention.

The importance of informing the youth regarding medication side effects, benefits, and risks cannot be overstated. The procedure at Cheltenham Youth Facility for informing the youth and their guardians of medication therapy is excellent. Of the charts reviewed, four of the youth were on medication. Of these youth, all charts had an informed consent for each medication that the youth was prescribed.

The informed consents included the name of the youth and the name of the medication being prescribed. They contain the benefits of the medication, the reasons for taking it, the risks, and the side effects of each medication. The forms were also signed by the youth and the behavioral health staff. Impressively, the guardian also either signed the form or it was noted that the guardian was contacted by phone and consent was given over the phone

Also, of note, at the top of the behavioral health assessments is an inclusive explanation of confidentiality and the possible disclosures that DJS may have to make under certain

circumstances. This information is important to convey to the youth, not only because it is part of the standard, but because the more transparent the treatment process is to the youth, the better able the clinician will be able to process relationship management issues.

RECOMMENDATIONS

Cheltenham Youth Facility has reached Superior Performance on this standard.

- This process should be adopted by the other detention centers within the state of Maryland.

PSYCHOTROPIC MEDICATION MANAGEMENT	RATING: Performance

STANDARD

Written policy, procedure, and practice require that psychotropic medications are prescribed, distributed, and monitored properly and safely.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

When the decision is reached that a youth should take medication, active monitoring by all caretakers is essential. Youth should be watched and questioned for side effects because many young people simply do not volunteer information. They should also be monitored to see that they are actually taking the medication and taking the proper dosage on the correct schedule.

During this review period, 36% of detained youth were on psychotropic medications. Of the charts reviewed, five of those youth were on medication. In all of these charts, the reason for the medication was noted. In no chart was there a refusal by the youth to take the medication. Of that the youth on medication, 41% of them were being treated with Benadryl, mostly for adjustment disorders.

Many DJS youth have sleeping difficulties due to the new setting, a mental health problem and/or stress about their current situation. Sleep logs should be conducted for youth who are having difficulty sleeping prior to prescribing medication and the behavioral health staff are aware that this is good practice. Proper sleep hygiene is also important as these youth may not have had consistent sleep routines in the past. No requests for sleep logs were noted in the chart, so though they are known to be beneficial, it may be useful to continue to remind the staff on the sleep log process and its benefits.

Proper diagnosis and medication protocols are important. Understanding the rate of effectiveness would help treat youth more effectively and accurately. It was highly recommended by the CRIPA Mental Health Monitor that monitoring and documenting

the effectiveness of medication would be helpful in the pursuit of even more successful treatment and the QI Team agrees.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Request and complete sleep logs on youth who are having difficulty sleeping.
- Monitor and document the effectiveness of medication regimes.

BEHAVIORAL HEALTH SERVICES — RATING: Performance

STANDARD

Written policy, procedure, and practice require that appropriate mental health and substance abuse treatment and emergency services are provided by qualified mental health professional and substance abuse counselors, that it is integrated with psychiatric services when applicable, and that it is appropriate for the adolescent population. Behavioral health issues are also considered when providing safe housing for youth at the facility.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Youth can have behavioral health disorders that interfere with the way they think, feel, and act. Behavioral health influences the ways youth look at themselves, their lives, and others in their lives. For some youth, contact with the juvenile justice system is often their first and only chance to get help with their mental health and substance abuse issues so effective behavioral health services within DJS facilities are crucial for DJS youth.

From review of the charts, it appears that youth generally meet with behavioral health staff at a rate that is individualized to the youth's needs. In one instance, a youth was receiving counseling daily. Individually tailored behavioral health plans are a positive adaptation as long as all youth are seen at least weekly. This seems to be the norm at Cheltenham.

Eighty-six percent of charts reviewed documented that youth received mental health treatment. Fifty percent of charts reviewed gave evidence that the youth received substance abuse counseling. Fourteen percent documented that substance abuse treatment was not needed. Substance abuse education groups should be conducted for all youth in detention. A flyer promoting a youth substance abuse 12 step group was posted in one of the cottages. Information regarding recovery displayed in the cottage is a positive step toward addressing youth substance abuse issues. Substance abuse process groups are not yet included but would be beneficial to youth; these would not simply inform youth about why drug and alcohol abuse is negative, but would examine their feelings and explore in a more in-depth way why they use.

Six of seven charts reviewed showed comprehensive psychiatric treatment. Charts indicated that youth were evaluated in depth initially and followed up regularly by the psychiatrist. The psychiatrist expressed a professional, knowledgeable, and caring attitude toward the youth upon interview. As mentioned earlier in this report, it would be beneficial to monitor and document the effectiveness of psychotropic medications in order to gain knowledge regarding how to best treat this population.

Cheltenham has in place a process for emergency service. Youth who have emergency behavioral health issues are sent to Southern Maryland Hospital Center when acute, and sent to Spring Grove Hospital Center for longer term evaluations. Housing at Cheltenham is safe and separated by pertinent characteristics, such as age, level of aggression, size, etc.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Add substance abuse process groups (for addressing feelings) to the therapeutic regime.

TREATMENT PLANNING — RATING: Performance

STANDARD

Written policy, procedure, and practice require that all youth in the facility in need of behavioral health treatment will have a signed collaborative treatment plan that addresses, at a minimum, a behavior management plan, and mental health and substance abuse issues as indicated. Behavioral health records will provide evidence of collaboration and communication among team members working with a youth, while maintaining the youth's confidentiality.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

A collaborative treatment plan, following a thorough assessment, identifies the youth's strengths and needs while assisting the clinician in focusing on the youth's most severe problems and barriers to recovery. The treatment plan, like the assessment, becomes multidimensional. Reassessment of youth needs and responses to treatment strategies allows the individualized treatment plan to become an evolving document, changing as youth issues are resolved, when outcomes are met, or when treatment strategies do not achieve the desired effect. Perhaps most importantly, youth can be more effective partners in their own treatment when the problems being addressed and the desired outcomes are clearly articulated.

The treatment planning process at Cheltenham Youth Facility is outstanding. The process should be adopted at all DJS detention facilities in Maryland. In is important that the treatment service plan process is collaborative among disciplines at CYF as well as inclusive of the community probation officers. Also important is that the youth is an integral part of the process.

The treatment plan should be placed in the chart so that all appropriate staff can have access to it, thus guiding decisions regarding youth's care. During staff interviews it was stated that this is in process. It is also important the Discharge/ Transition Plan for each young man is addressed in the treatment plan so that it is continually acknowledged and addressed from the time of admission. Communication and continuity of care is extremely important in the lives of these youth.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Place the treatment plan in the chart so that all appropriate staff can refer to it and note progress as it is made.
- Incorporate Transition/Discharge Planning as a goal on all treatment plans.

BEHAVIORAL HEALTH TREATMENT DELIVERY	RATING: Performance

STANDARD

Written policy, procedure, and practice require that all youth at the facility identified with behavioral health issues receive mental health and substance abuse treatment as indicated. Family involvement should be highly encouraged and crisis intervention services should be available in acute incidents. All admitted youth should receive alcohol and drug abuse prevention /education counseling.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

The juvenile justice system is focusing extraordinary efforts on addressing concerns about the mental health needs of delinquent youth. Recent advances in understanding mental disorders of adolescence have been joined by new neuroscience information about brain development in adolescence, as well as behavioral science findings documenting socio-emotional differences between adolescents and adults that offer different explanations for the illegal acts of youth. These advances are confirming that adolescents are better served by a different response to their offenses. It is therefore of the utmost importance that the behavioral health issues of youth in custody are addressed before the opportunity to do so passes.

Of the charts reviewed, seventy-one percent contained documentation of mental health groups and individual therapy. Not all youth are in need of intensive mental health counseling, but mental health groups can be offered to all youth on topics that are relevant to the population at large.

Of the charts reviewed, fifty-seven percent documented substance abuse groups and education. Twenty-nine percent documented individual counseling around the issues of substance abuse. It should be noted that not all youth are in need of substance abuse counseling and therefore it is not expected that all youth will receive it. Given the high prevalence of substance use among our target population it is important that all youth receive substance abuse education. Evidence that Cannabis Youth Therapy (CYT) is being conducted is a positive sign that substance abuse education is being provided. .

As mentioned in other sections of this report, crisis intervention services are available to youth as needed. Seventy-one percent of charts reviewed showed evidence of crisis intervention service delivery. Mental health professionals are available to counsel any youth in crisis.

Family involvement is documented as being very low. Fourteen percent of the charts reviewed showed direct face-to-face family involvement and another fourteen percent documented phone contact with family regarding youth's treatment. Seventy-two percent of charts reviewed did not show any sign of family involvement other that consent for psychotropic medications. Staff interviews corroborate a lack of family involvement but there are efforts to include family made by the behavioral health staff. The importance of family involvement can not be overstated related to its effect on the youth's prognosis and continuity of care. Ways to increase it should be explored.

Interviews with behavioral health staff revealed a desire to incorporate the behavior management system into treatment so that youth could receive points for good participation in behavioral health groups.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Monitor and evaluate family involvement by keeping track of the percentage of families that show up for family visitation and percentage of families that participate in family therapy. Brainstorm ways of encouraging families to participate more.
- Incorporate the Behavioral Management point system to cover participation in behavioral health groups.

TRANSITION PLANNING — RATING: Partial Performance

STANDARD

Written policy, procedure, and practice requires that staff facilitate appropriate transition plans for youth leaving the facility. Youth, and their guardian when appropriate, should receive information on behavioral health resources, a prescription for medication continuation, and assistance in contacting behavioral health aftercare services to schedule follow up appointments.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Discharge or transition planning is a specialized process for detained youth that occurs both in the facility and in the community. Discharge planning and the aftercare process refers to those activities and tasks that: 1) prepare juvenile offenders for entry into their communities or into a treatment facility; 2) establish the necessary arrangements and linkages with the full range of public and private sector organizations and individuals that can assist the youth with his behavioral health needs; and 3) ensure the delivery of prescribed services and medications to the youth upon exiting the facility.

Discharge and transition planning are a difficult undertaking because of the unpredictability of discharge dates. Discharge planning is mentioned in the initial behavioral health assessment which is a positive sign that it is a recognized need. Discharge planning should be addressed throughout the youth's detention.

For every youth, subsequent placement or home return should be ascertained prior to discharge and it should be ensured that the youth is not on suicide watch at the time of discharge. Any youth that has behavioral health issues should receive an aftercare appointment and instructions at the time of discharge. If the youth is on psychotropic medications, a prescription and follow-up appointment should be scheduled prior to youth discharge whenever possible. If the youth is discharged from court without warning, the appointments and prescriptions should be given to the youth's community probation officer who can then convey this information to the youth and his family.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Record the problems the facility is having with creating comprehensive discharge plans and send these issues to the QI team for technical assistance.
- Include Discharge/Transition Planning as a goal on the treatment plan that is addressed every thirty days by the Treatment Service Planning team.
- Contact family members/ guardians early in the treatment process so that their input is included in the Discharge Plan.
- Schedule follow-up appointments for behavioral health and medication maintenance. These appointment dates/times should be given to the youth and guardian when possible and to the Community Probation Officer to convey to the youth when the youth is no longer directly available to CYF.

SUICIDE PREVENTION

DOCUMENTATION OF YOUTH ON SUICIDE WATCH	**RATING: Partial Performance**

STANDARD

Written policy, procedure, and practice require that all newly arrived youth, youth in seclusion, and youth on suicide precautions are sufficiently supervised. Suicide precaution documentation must include the times youth are placed on and removed from precautions, the current level of precautions, the youth's housing location, the conditions of the precautions, and the time and active circumstances of the youth's behavior.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

All administrative, direct care, medical and clinical staff and all other personnel working with youth in the custody of the Department of Juvenile Services (DJS) are responsible for protecting that youth from suicidal or harmful actions by and to themselves in all facilities operated by DJS. In order to assure that this is done completely and satisfactorily, suicide watch precautions must be taken and always according to DJS policy.

Between the dates of 12-20-07 and 4-18-08, thirty-nine youth were on suicide watch at one time or another. The documentation on slightly over twenty percent of these charts was reviewed. At some time during each youth's suicide watch, all of the sheets exhibited exact checks conducted on the ten minute mark at least once. This was done for entire shifts in some instances. The facility leadership is aware that checks must be staggered, at random ten minute intervals, in order that the youth not be aware of when someone might be checking up on him. Exact checks give the impression of staff rounding up and not accurately noting when a check was made.

Observations also revealed that at times, the youth's location (school) rather than behavior (writing at desk) were indicated. Some hours did not have an adequate amount

of at least six checks, others were missing the dates, and still others appeared to be pre-dated. All sheets did list the youth's suicide level.

Reevaluation of suicide levels were conducted at appropriate intervals and documentation of such was placed in the chart. Suicide logs were complete and well done. Staff reviews of completed suicide watch logs were conducted regularly which is a positive sign that mistakes are being identified quickly.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Train new staff on the correct way to document on the suicide watch forms, and the importance of accuracy in documenting suicide watches.
- Ensure shift commanders are checking sheets and making notes of corrective action when exact checking or other anomalies are found.

ENVIRONMENTAL HAZARDS — RATING: Superior Performance

STANDARD

Written policy, procedure, and practice require that all housing for youth at heightened risk of self-harm is free of identifiable hazards that would allow the youth to commit suicide or other acts of self harm. In case of emergency, all direct care staff at the facility should have immediate access to appropriate equipment to intervene in an attempted suicide. Chemicals and other hazards are properly stored and locked.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

A tour of the Cheltenham Youth Facility demonstrated that all chemicals, mops and brooms were kept behind locked doors. All staff reported they carry cut down tools when on the unit. Staff observed did have cut down tools on their person. Rooms were observed to be free of contraband.

In the activity rooms in all three cottages, windows were adorned with corded blinds; the use of the cord through a vent or other fixture could pose a suicide risk if youth were ever left in a room unattended. This is not an imminent danger because DJS staff are not to leave a youth in the activity room alone at any time (and the door is locked when youth and staff are not using it.) But when these blinds need to be replaced, window treatments that are safe and without cords should be purchased.

RECOMMENDATIONS

The facility has met the Superior Performance rating. One suggestion is offered:

- Purchase non-corded window treatments when replacements are needed.

CLINICAL CARE FOR SUICIDAL YOUTH — RATING: Performance

STANDARD

Written policy, procedure, and practice require that timely suicide risk assessments, using reliable assessment instruments, are conducted at the facility for all youth exhibiting behavior that may indicate suicidal ideations to determine whether a youth should be placed on suicide precautions or whether the youth's level of suicide precautions should be changed. Youth at a facility who exhibit suicidal ideations or attempts should receive timely, appropriate, and professional mental health services. Youth should not be restricted from programs and services more than safety and security needs dictate. All pertinent staff should review all completed suicides and suicide attempts at the facility for policy and training implications.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

All of the charts reviewed documented that suicide risk assessments are done by professional mental health staff in a timely manner when the need is indicated. Reevaluation of a youth's mental status and level were routinely conducted while the youth was on suicide watch. The reasons for being placed on suicide watch and the precautions to be taken with a particular youth were also documented. In was not evident that any youth were unfairly or unnecessarily restricted from programming due to being placed on suicide watch.

One concern was that staff interviewed reported that, though rare, youth have been discharged from Cheltenham while still on suicide watch. Communication of the youth's mental health needs (to the court, the community case manager, the treatment facility and/or the parent or guardian) must include safety concerns about his suicide watch status so that a potentially lethal situation does not occur.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Assure that the youth is not on suicide watch precautions at the time of discharge.
- If he is on watch when he has a court appearance, inform the court of his status when he is transported there. If a youth is released from court while on watch, ensure notifications go out to the family, community case manager, and the treatment facility (if applicable) of that status.
- Follow up with the community case manager to ensure his needs are being met.

EDUCATION

SCHOOL ENTRY	RATING:	Performance

STANDARD

Written policy, procedure and practice document timely enrollment of all students into the educational program. The school will receive a daily roster of students. The receipt of student records should occur in a timely manner.

SOURCES OF INFORMATION

- Interview with record staff
- Interview of Guidance Office staff
- Review of orientation sign-in log
- Review of 34 student folders (22 general education, 12 special education)
- Review of Daily Population Roster
- Review of the Child Find Tracking Log

REFERENCES

- COMAR 13A.08.07.01: Education-Student in State Supervised Care-Transfer of Educational Records
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

The QI reviewer interviewed the school guidance counselor and her assistant to get an overview of the enrollment process. According to the guidance counselor, the students are brought to the guidance office on the first or second day of their entry to the facility. The students then receive an orientation to the school that includes an overview of the school schedule and course offerings, the development of the students' Personalized Education Plan (PEP), an overview of graduation and GED requirements in the state of Maryland, an overview of community services hour requirements, a Transition summary that includes a career interest inventory, the student education interview and the STAR assessment.

A comparison of the Orientation Log book and the Daily Population Roster indicated that the majority of students receive orientation to the school program by their second day in the facility following court. The guidance office also highlights students that score low on the STAR assessment and provides that information to the special education staff and the reading specialist. Guidance staff reported that one challenge is providing orientation and screening activities to the students in the Re-Direct Program efficiently. The school principal indicated that the DJS IT department is currently working to assist this process.

The CYF School employs a full-time records clerk who requests all of records from the students' previous schools. A review of records indicated that the first request for records was usually completed within three days following facility admission. Second requests

were also completed in a timely manner when necessary. The school consistently contacted the DJS Department of Pupil Services for assistance with records that were not retrieved from previous schools following the second request. The personnel at the Pupil Services office is used by DJS and MSDE detention schools to locate difficult-to-retrieve educational records from school systems throughout Maryland and occasionally, from out of state systems. DJS established a standard requiring that its schools retrieve 90% of students' previous educational records within five days of enrollment. A review of the school's Child Find Tracking documentation found that the school fell just short of that mark at approximately 86%.

As was observed during the last QI Review, the school received a Daily population sheet that included the students' dates of entry, units, and jurisdictions. The population sheet also indicated which students were not in the facility and the reason.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Ensure that each student in the Re-Direct Program is assessed using the STAR screening instruments in a timely manner by loading the software program onto computers in the Re-Direct building and training Re-Direct education staff to use the program..
- Ensure the records are requested according to COMAR 13A.08.07.01: Education-Student in State Supervised Care-Transfer of Educational Records

CURRICULUM & INSTRUCTION — RATING: Performance

STANDARD

Facility schools will ensure that they provide instruction appropriate to the varied needs and abilities of the students enrolled. They should operate on a standard schedule, provide students with a consistent school day, provide instruction appropriate to individual students' strengths and needs, provide pre-GED & GED instruction as appropriate, provide extracurricular and enrichment activities & events, integrate computer assisted instruction in the curriculum and provide library services. Facility schools will also ensure that students in alternate settings (i.e. infirmary, seclusion and orientation) are given access to assignments and instruction comparable to others students in the facility.

SOURCES OF INFORMATION

- Review of school schedules
- Observation of transitions to and from class
- Classroom observations
- Interview of teaching staff
- Student interviews
- Administrator interview

REFERENCES

MSDE Guidelines
DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

As with the last QI review, a variety of instruction methods were demonstrated by teachers. The reviewer observed one-on-one instruction, computer assisted instruction and the use of A/V aids. Staff generally reported that they had the materials that they needed on a daily basis. The school has a functioning library and media specialist and students are allowed to take books with them. Currently, the school has no students receiving Pre-GED or GED instruction. The school principal indicated that there is a question within the DJS Education Department as to whether or not students in detention are to receive these services.

The school maintains a monthly calendar of extra-curricular activities including guest speakers, parent-teacher nights and assemblies. Students report that they are offered a variety of activities.

As with the last review, the major concern for the CYF School is getting the students to school on time. Observation over three days indicated that the three of the four units inside of the gate got to school prior to the 8:15 AM start of school. One unit was at least two to five minutes late each morning. Following lunch the problem was greater, with units returning up to 27 minutes late. The facility has attempted to curb this problem by

creative measures including feeding two units in the dining hall at once. However, the problem still remains.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Develop a system to get students to school on time daily.
- Ask the DJS Educational Department to determine what pre-GED and GED services will be provided in detention schools.

SCHOOL STAFFING & PROFESSIONAL DEVELOPMENT	RATING: Performance

STANDARD

The Facility School will maintain a sufficient number of certified staff to provide appropriate education to all students, including related services providers. The school should provide meaningful staff development opportunities to teachers and support staff to enhance their ability to effectively educate youth in detention settings.

SOURCES OF INFORMATION

- Roster of teaching staff
- Administrator interview
- Teacher and IA interviews

REFERENCES

- No Child Left Behind Act of 2001, (NCLB), P.L. 107-110
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

The CYF school staff consists of one principal, one teacher supervisor (who is also the school's media specialist), one office secretary, one records clerk, one math teacher, one reading specialist, two English teachers, one life skills teacher, one Career Exploration teacher, two social studies/Government teachers (one of which is certified in special education), one graphic arts teacher, one horticulture teacher, one carpentry instructor, one special education lead teacher, four special education teachers, four instructional assistants, and one guidance counselor. The school contracts with private providers for related services in counseling and speech language pathology.

The school has a vacancy for a PE teacher. The school is also in the process of hiring a math teacher and a carpentry teacher. The principal indicated that he is trying to develop a fine arts component to education, but has yet to secure the positions.

Teachers reported that they are provided staff development activities throughout the year. However, new teachers indicated that they did not feel as though they were properly oriented to the position and are in need of more training.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Continue to hire needed staff. Frequently assess the needs of the school to determine appropriate staffing needs for the youth.
- Develop a new teacher orientation program.

SCREENING & IDENTIFICATION	RATING: Performance

STANDARD

Qualified professionals shall provide prompt and adequate screening of facility youth for special education needs, including identifying youth who are receiving special education in their home school districts and those eligible to receive special education services who have not been so identified in the past.

SOURCES OF INFORMATION

- Review of special education roster
- Review of Child Find Tracking form
- Interviews with records and teaching staff
- Review of student folders

REFERENCES

- Individuals with Disabilities Act (IDEA), 20 U.S.C. 1400-1490
- COMAR 13A.08.07.01: Education-Student in State Supervised Care-Transfer of Educational Records
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

Using the record retrieval process outlined previously in this report, the Cheltenham (CYF) School does a very good job of identifying students who already receive special education services. Teachers and related service providers are provided with a special education roster indicating the students, their location in the facility, disability code, related services and meeting dates.

The school also has a referral process for identifying students that may benefit from special education services. Most teachers were able to articulate the procedure for referring students who demonstrate academic and/or behavioral needs. Those teachers who were not able to articulate the process were in every case the newer teachers. In addition, the teachers participate in weekly treatment team meetings with on site case managers, community case managers, mental health staff, medical staff and parents.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Ensure that newer teachers are trained in the student referral process.

PARENT, GUARDIAN & SURROGATE INVOLVEMENT	RATING: Performance

STANDARD

Written documents show that parents, guardians or surrogate parents are notified of and invited to participate in evaluations, eligibility determination, Individualized Education Programs (IEPs) development and team meetings, and decisions regarding provisions of special education services.

SOURCES OF INFORMATION

- Review of IEP documentation
- Interviews with record retrieval and teaching staff
- Review of student folders
- Review special education files
- Interview of parent surrogate
- Review of Parent Surrogate Training materials

REFERENCES

- Individuals with Disabilities Act (IDEA), 20 U.S.C. 1400-1490

SUMMARY OF FINDINGS

Student files included copies of IEP Team Meeting invitation letters with contact logs that indicated attempts to contact the students' parents or guardians. There were at least three attempts to contact the parent or guardian documented in each of the 12 files. The log was good, but could include more detail about the parents' specific responses and also might also include notes of communication with the young man's community case manager. Parents participated in six of the eight IEP Team Meetings that had already occurred and that were included in the QI review of documentation in this area.

The CYF School also maintains a list of trained parent surrogates to attend meetings in cases where parents and guardians are not available. The QI Reviewer contacted one of the surrogates who confirmed that he was trained by the school staff in parent surrogate responsibilities and that he is called to participate in IEP meetings as needed.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Maintain a contact log that also includes notes of communication with the students' community case manager.
- Enhance the entries to the log to include more detail about the parents' specific responses.

INDIVIDUALIZED EDUCATION PROGRAMS	RATING: Performance

STANDARD

Written policy, procedure and practice provide that Individualized Education Programs are completed according to federal, State and departmental guidelines.

SOURCES OF INFORMATION

- Review of special education student files

REFERENCES

- Individuals with Disabilities Act (IDEA), 20 U.S.C. 1400-1490

SUMMARY OF FINDINGS

A review of records indicated that the IEP teams were properly constituted with the needed participants, including related service providers. The IEPs indicated a continuum of services including consult, inclusion, and a variety of pullout options. Meeting notes seemed to demonstrate that the team was considering the best options for the student.

The meetings were all held within reasonable timelines, but because of the transient nature of the population, the process of scheduling meetings needs to occur more quickly. Students' meetings were scheduled about 20 to 30 days after enrollment. During that time many students would have been released prior to the meeting date. IEP meetings should be scheduled as soon as the student is identified as needing services.

Related Services documentation seemed, for the most part, to be appropriate. Entries were consistent in time and frequency and appeared to correspond to the services identified on the students' IEPs.

RECOMMENDATIONS

In order to reach Superior Performance in this area, it is recommended that the facility:

- Ensure that IEP team meetings are scheduled as soon as students are identified as needing services.

CAREER TECHNOLOGY & EXPLORATION PROGRAMS	RATING: Performance

STANDARD
The facility will provide students opportunities to explore career interests and to develop skills useful in obtaining employment.

SOURCES OF INFORMATION
- Review of school schedule
- Interview with school staff
- Interview of school administration
- Classroom observation

REFERENCES
MSDE Guidelines

SUMMARY OF FINDINGS

The CYF School has several career exploration options. The school offers horticulture, computer classes and carpentry. In addition, the school offers a Career Exploration class in which students develop skills such as resume writing, interviewing and applying for jobs. According to the school principal, the school also has the equipment and staff to offer a graphic art class, but that space where the equipment is housed is shared with the carpentry class. Because of the space issue, both programs cannot run at the same time. If more space were available, yet another option could be offered to the youth.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Designate space for the operation of the graphic art design class.

SECTION 504 PLANS — RATING: Performance

STANDARD

The facility will ensure that accommodation and services are provided according to each student's Section 504 plan. The facility will also ensure that students' Section 504 plans are reviewed and revised as needed.

SOURCES OF INFORMATION

- Interviews with education staff
- Student files

REFERENCES

- Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794
- DJS Section 504 Guidelines

SUMMARY OF FINDINGS

During the QI Review, there were no students with a Section 504 plan. However, the school did provide three files of students who were released from the facility. Each file indicated that the students' plan was reviewed at a meeting at CYF. The parents were invited to each of the meetings and in two of the three cases, parents participated in the development of the plan. Staff members at CYF indicated that they received copies of the plans from the guidance office. However, some of the newer staff members were unsure of what a 504 plan was.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Ensure that new staff members are trained on Section 504 procedures.

STUDENT SUPERVISION — RATING: Superior Performance

STANDARD

The facility will ensure that staffing is appropriate to supervise students in the educational setting, as well as during transitions to and from the school setting.

SOURCES OF INFORMATION

- Classroom observations
- Observation of transitions
- Student interviews.

REFERENCES

- Maryland Standards for Juvenile Detention Facilities

SUMMARY OF FINDINGS

As stated earlier in this report, there is a concern about the movement of youth to school in the morning and the afternoon. However, the transitions between classes are orderly and seem to move efficiently. Students move in single file lines with very little noise and disruption. Staffing appears to be sufficient to monitor student behavior in the classroom. In addition to the direct care staff members assigned to each unit, there is a shift commander that is assigned to the school who manages movement, coverage of staff for bathroom breaks and communication among staff. This is a very positive addition.

RECOMMENDATIONS

The school is in Superior Performance with this standard.

SCHOOL ENVIRONMENT & CLIMATE	RATING: Performance

STANDARD
The facility will ensure that the school setting is a safe environment conducive to learning and that staff are supported in their jobs.

SOURCES OF INFORMATION
- School observation
- Teacher interviews
- Direct care staff interviews

REFERENCES
N/A

SUMMARY OF FINDINGS

For the most part, both school and direct care staff indicate that the school environment is positive. Most teachers indicate that they are comfortable with the leadership given by the principal and the supervision of students and the assistance of the direct care staff in the classroom. Direct care staff members interviewed indicated that they were treated respectfully by most of the education staff.

One concern that was pervasive among the staff was the need for a cleaner facility. Staff noted that the school does not have a cleaning contract and that teachers are responsible for cleaning the bathrooms in the classrooms that are used by the students. They were also concerned that the trash is not emptied daily and that school is generally not very clean.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Acquire consistent cleaning services for the school.

MEDICAL CARE

HEALTH CARE INQUIRY REGARDING INJURY	**RATING: Performance**

STANDARD:
Written policy, procedure, and practice ensures that all youth are seen by medical staff after any incident in which they are involved, regardless of whether there is an injury, shortly after the incident occurs.

SOURCES OF INFORMATION:
Facility Incident Reports Jan.15-Apr.15 2008
Interview with Superintendent
Interviews with youth
Observation at facility

REFERENCES:
DJS Incident Reporting policy (MGMT-03-07); Photographing of Injuries policy (RF-11-05); Reporting & Investigating Child Abuse policy (MGMT-1-00)

SUMMARY OF FINDINGS

Prompt medical care after an incident protects each youth's health and safety. Even when no injury seems to be present, a medical check and opinion is necessary to ensure that the young person is not injured or does not need emergency care. Cheltenham has 24 hour nursing care. Because of this, youth involved in an incident can and should see the nurse immediately following any incident, and certainly within 1-2 hours unless there are other extenuating circumstances.

In a review of 11 incidents involving 20 youth, specifically chosen for their classification as youth-on-youth or youth-on-staff assaults or restraints (which in all cases would require a visit to the nurse), all 20 youth had a Nursing Report of Youth Injuries form (body sheet) in the incident report packet and all had photographs of the youth's injury or lack of injury.

In all of the 20 sheets, the nurses filled out the body sheet properly, including as required the Injury Severity Rating (ISR) and what the youth's account of the incident was. In 15% of the body sheets reviewed, the times the youth were seen by the nurse were not noted, but the body sheet was otherwise filled out completely in those cases.

The only concern noted that is in definite need of improvement is in the times the youth sees the nurse. DJS policy requires they be examined "as soon as possible" after an allegation of abuse, and policy requires that the nurse be notified of incidents as soon as they have occurred so that they can be taken to Medical for evaluation. Of the 20 youth evaluated by the nurse, 9 out of 20 (or 45%) either had no time indicated when they were

seen (4 of 20) or had a time indicated that was more than 2 hours after the incident occurred (5 of 20). Oftentimes, youth are too agitated to immediately go to Medical and have to calm down first. It is recommended that the nurses always indicate the time they saw the youth and that staff, if they have to wait more than a couple of hours after the incident, note on the incident report why there may have been a delay.

In one alleged youth-on-youth sexual abuse case, the youth was seen by the nurse, but late. The incident was alleged to have occurred in the morning, was reported by the youth at 4:54pm, and the youth did not see the nurse until 12:30am. Not only was there a concern he was taken from the cottage in the middle of the night to go to medical instead of being seen earlier that evening (the incident did not allege or raise concern that there would have been any physical injury), but the CPS call was not made until 11pm. Prompt nursing attention in any case is crucial, but is equally important in allegations of abuse, even without report of injury from the youth. In one other body sheet, though the alleged abuse was reported timely to CPS, the nurse left that section blank on the body sheet.

RECOMMENDATIONS

In order to reach Superior Performance status, the facility must:

- Ensure youth see the nurse after every incident as soon as it is possible. If for some reason the youth must be seen more than 1-2 hours after an incident (either due to his behavior or for any other reason), document that fact and the reason on the incident report.
- Ensure allegations of any type of abuse are reported to the nurse immediately and that the youth is seen for examination without delay.

Statement Regarding Health Assessments,
Medication Administration, Dental Care,
Medical Records Retrieval & Special Needs Youth

The Cheltenham Infirmary is currently undergoing a complete renovation due to CRIPA-required changes in space use and building design; DJS is working on these plans and renovations through the months of April, May and June 2008 so the Medical Standards will not be able to be assessed during this review period due to the youth being moved to other infirmaries and files and staff being temporarily displaced. The QI Team will plan a targeted review of the five Standards above within six months but definitely prior to September 30, 2008.